

LOUISVILLE MEDICAL NEWS:

A WEEKLY JOURNAL OF MEDICINE AND SURGERY.

EDITED BY

RICHARD O. COWLING, A. M., M. D.

PROFESSOR OF SURGICAL PATHOLOGY AND OPERATIVE SURGERY IN THE UNIVERSITY OF LOUISVILLE

AND

WILLIAM H. GALT, M. D.

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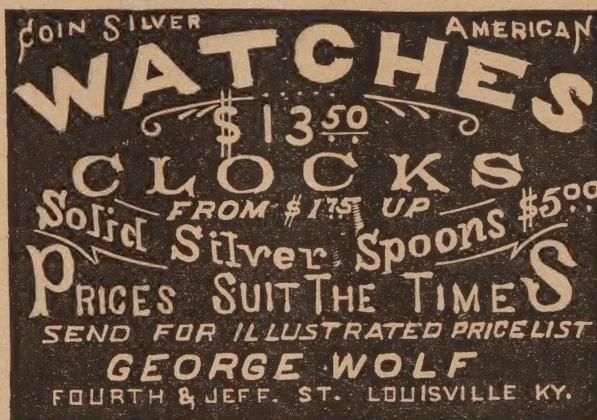
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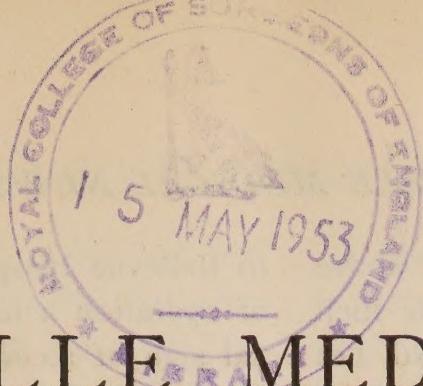
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LOUISVILLE MEDICAL NEWS.

"NEC TENUI PENNA."

Vol. IV.

LOUISVILLE, SEPTEMBER 15, 1877.

No. II.

Original.

AMPUTATION OF THE PENIS.

Cases illustrative of the Management of the Extremity of the Urethra after Amputation close to the Pubes.

BY JOHN W. S. GOULEY, M. D.,

Professor of Diseases of the Genito-urinary System in the Medical Department of the University of New York, Surgeon to Bellevue Hospital, etc.

CASE I.—*Amputation of the Penis for Epithelioma.*—*Recurrence of the disease in the stump and in the crura, with atresia of the extremity of the urethra.—Proposed ablation of the remainder of the organ, and formation of a sort of perineal vulva by stitching the edges of the urethra to those of the perineal incision.*

Timothy R., aged forty-five, was always well until January, 1875, when he noticed a small whitish spot on the inner surface of the prepuce, which rapidly increased in size. In two months this patch ulcerated and caused great pain and uneasiness. In June, 1875, he entered a hospital, where his complaint was regarded as chanchroidal, and treated accordingly for three months, but with no good effect. Patient was afterward treated at the New York Dispensary, where the diagnosis of epithelioma was made, the disease having progressed so rapidly as to invade a large portion of the penis. Amputation close to the pubes was advised and performed by Dr. Bronson on or about September 22, 1875. A very short stump was left, and the disease reappeared in the remaining portion of the organ in May, 1876, when he came to Bellevue Hospital, suffering great pain in and around the ulcerated tumor, which was quite hard at its base and two inches in diameter. Both cruræ of the penis soon became involved, the left to a

greater extent than the right. The patient was anæmic, sallow, emaciated, and dispirited. His appetite and digestive function were greatly impaired. The urine was discharged from a small orifice on the right side of the tumor. The surrounding skin was then very little implicated. Palliatives were at first used, such as chromic acid, and also iodoform locally and arsenic internally.

By the 5th of August, 1876, the tumor had increased considerably in size, and a second growth merging into the first had appeared in the lower part of the hypogastric region on the right. The skin covering this latter growth ulcerated on August 10th, and gave issue to a thin purulent discharge.

The patient was seen by my colleagues, Drs. Stephen Smith, A. C. Post, and H. G. Piffard, who assented to the operation I proposed, which was to have been the ablation of the tumors, together with the remainder of the penis, including the crura. The urethra was to be left long enough to be slit longitudinally and stitched to the edges of the skin, so as to form a kind of vulva with a large urethral orifice. But the patient declined to submit to the operation, left the hospital on August 23, 1876, and has not since been heard from.

I was induced to propose the latter step of the operation from the observation of a case the account of which is given in my book on diseases of the urinary organs, pp. 177-179. I first saw the man in November, 1869. "Seven years before he was struck by a fragment of shell, which deeply lacerated the dorsum of the penis to within half an inch of its root. Five days after this it was found necessary, on account of slough-

ing, to remove the penis at the point above indicated, leaving a stump half an inch long, the extremity of which would not heal; meanwhile the urine continued to flow by the natural passage, but in decreased stream. The stump was afterward variously cauterized, and in the course of ten months healed, leaving a very narrow outlet for the urine. An abscess then formed in the perineum, was opened, and gave exit to pus and urine. From that time he passed no water through the meatus, which was completely obliterated. . . . The perineal opening, . . . which resembles the vulva and meatus urinarius of the other sex, . . is situated exactly in the median line, three quarters of an inch in front of the anus. He urinated three or four times a day, and had no bladder complication."

The liability to atresia of the urethral orifice when the canal is simply cut across in amputation of the penis is known to be so great that several plans have been proposed to obviate it, all of them consisting in slitting the urethra and stitching its edges to the adjoining skin, and they have usually fulfilled the desired object. Owing to the fact that this precaution is too often neglected, I venture to place on record some observations illustrative of its good effect in extreme cases.

CASE II.—*Epithelioma of the Penis.—Amputation close to the pubes, followed in a few months by atresia of the meatus, and then by a perineal fistula.—External perineal urethrotomy without conductor, and suture of the urethra to the perineal integument.*

John R., aged fifty-two, was admitted to Bellevue Hospital on May 9, 1877, with the following history: About twelve months before he observed a small hard "lump" on the prepuce, which increased very rapidly, and involved the whole pendulous portion of the penis. It was recognized to be malignant, and amputation of the penis close to the pubes was performed in December, 1876. Very soon after the operation he began to suffer from dysury, and could retain his urine only ten minutes. When admitted

to Bellevue Hospital there was at the seat of operation a hard cicatrix, but no external sign of recurrence of the disease. The outlet for the urine was so narrow that a small probe could not be introduced, and the urine constantly dribbled, causing excoriation of the scrotum. There was a small fistulous opening in the center of the perineum, through which a few drops of urine oozed.

On account of the absence of a projecting stump of penis, and of the certainty of the continuance of scrotal irritation by the flow of urine, even if it had been possible to maintain the patency of the urethral orifice, I proposed to make an external perineal urethrotomy, and to stitch the edges of the urethra to those of the skin. On May 11, 1877, the patient was etherized, and an attempt made to introduce a filiform guide into the bladder through the urethra; but this was found impossible. Not only the meatus, but an inch or more of the urethra beyond it was much indurated and strictured. I was therefore obliged to do the operation without a conductor. I made a longitudinal incision three inches in length through the perineal integuments in the median line, and cut open the canal longitudinally for an inch and a quarter, and applied a number of sutures so as to attach the cut edges of the urethra to those of the skin. The urethral incision extended back to the middle of the bulbous portion. The bleeding did not exceed two ounces. Primary union took place throughout nearly the whole wound, and the function of urination was performed with the greatest satisfaction to the patient. The opening resulting from the operation resembled a small vulva. The man was discharged from the hospital two weeks after the operation.

CASE III.—*Epithelioma of the Penis.—Amputation close to the pubes, and external perineal urethrotomy with conductor.—Edges of the urethra stitched to those of the skin, so as to make a kind of vulva.*

John M., aged forty-four, had congenital phimosis; otherwise was well until the latter part of February, 1877, when he noticed a

small growth between the glans and prepuce. This increased so rapidly that when I first saw him, at Bellevue Hospital, May 14, 1877, the penis was two inches in diameter. Urination was difficult and painful, and the urine dribbled so much as to excoriate the prepuce and scrotum. The whole sheath and subcutaneous connective tissue of the penis were infiltrated with cancerous matter, and there was a very offensive sanguineous discharge from the preputial orifice. The patient suffered great pain at the seat of disease, especially during the night. About two weeks before I saw him a swelling had appeared near the root of the penis on its dorsal aspect, and extended up an inch to the hypogastric region, and when opened gave issue to some bloody matter. Soon afterward a fungoid mass protruded from the wound. At about the same period the lymphatic glands of both groins became involved. The patient, though somewhat emaciated and pallid, was in a tolerably good general condition.

On May 16th the end of the penis had become so much swollen, the discharge so much more offensive, and the obstruction to the passage of the urine so great, that the patient was etherized, and I slit the prepuce, and found a part of the growth, involving the glans and prepuce, in a gangrenous state. This operation had the effect of facilitating urination.

On May 18, 1877, I concluded to amputate the penis close to the pubes, and to dispose of the urethra as in Case II. The patient having been etherized, a curvilinear incision was made on either side of the root of the penis, beginning, in the median line, at about one inch and a half above the level of the pubes, and ending a little below the peno-scrotal junction. This elliptical wound exposed the cavernous bodies, which were then transfixated by a large knitting-needle, the ends of which rested on either groin and served to prevent retraction of the stump. A smaller knitting-needle was passed across and through the urethra on the same plane as the first needle, and with Richardson's

serrated scissors the penis was severed at a point about one eighth of an inch anteriorly to the needles. There was very little loss of blood, and only four or five vessels required the ligature besides those of the subcutaneous tissue, which were secured in the pubic and scrotal portions of the wound. The mouth of the urethra was easily found on account of the needle, which indicated its situation, and a grooved staff was introduced through it into the bladder. A scalpel was then plunged into the center of the perineum and into the groove of the staff, and all the tissues, including the skin, were divided at one sweep of the knife from behind forward and from below upward. The urethral cut was about an inch and a quarter in length, including half of the bulb, and the cutaneous wound three inches. The bleeding did not exceed two ounces. The edges of the urethra were stitched to those of the skin with fine silk, and the result was the formation of a sort of vulva. The wound in the pubic region was closed with silver wires after removing the knitting-needles. The perineal wound united primarily, but that in the pubic region suppurated and was never completely healed.

A catheter was periodically introduced by the perineal opening to relieve the bladder, except twice, when the patient urinated before the catheter could be passed. The result was that some urine made its way to the anterior part of the urethra, and issued through its transversely-cut extremity; and there followed urinous infiltration of the connective tissue of the scrotum and groins, causing abscesses, which had to be opened on May 25th. Afterward he was enabled to urinate spontaneously, without the occurrence of this accident, in a large jet, and experienced the greatest relief from the operation. But the disease, which had already attacked the inguinal glands, soon recurred in the stump, and progressed so rapidly that further surgical interference was out of the question. The operations were intended to give temporary relief only and to facilitate urination, and so render existence tolerable

during the short time the patient had to live. Early in July there were manifest symptoms of pulmonary cancer, and toward the last there were cerebral symptoms. He died, comatose, on August 16th. No autopsy was permitted.

To prevent infiltration of urine, I intend in future to follow Demarquay's example of detaching the urethra from the cavernous bodies; then to slit it longitudinally, and stitch its free extremity to the upper commissure of the perineal wound and its edges to those of the skin.

This mode of managing the urethral extremity in amputation of the penis is not new; nevertheless, it is none the worse for its age. How old it is or who originated it I have not now the leisure to inquire; but, by casually looking into a few authoritative works, I find that in 1832 Delpech, of Montpelier, at the St. Eloi Hospital, amputated the entire penis, and bisected the scrotum so that each testicle was inclosed by the aid of sutures in a separate scrotum, the extremity of the urethra being placed at the commissure of the bifid scrotum. The result was satisfactory. The patient was able to urinate well in a crouching position.

That in 1844 Lallemand, also at the St. Eloi Hospital, Montpelier, performed the same operation, with like result.

That in 1855, at St. Eloi Hospital, Bouisson removed the entire penis, repeating Delpech's operation; and that on the next day he stitched the end of the urethra to the edges of the cutaneous wound at the commissure of the bifid scrotum. But primary union did not occur. The ultimate result was excellent. The patient urinated in a good jet by drawing asunder the two testes. In his *Tribut à la Chirurgie* Bouisson gives a very good drawing of the case.

That in 1854 Demarquay amputated the entire penis, including the crura (for epithelioma), and attached the slit urethra to the edges of the wound in the perinæum, making a species of vulva.

That Mr. Erichsen (*Lancet*, Dec. 26, 1857, vol. II, p. 648) performed external perineal

urethrotomy in November, 1857, with the object of establishing a perineal opening to facilitate urination, in a case of atresia of the urethral orifice, which had followed amputation of the penis for cancer.

And that in May, 1877, Dr. Johnston, of Baltimore, had done an external perineal urethrotomy, "and the sides of the urethra were attached to the edges of the incision in the perinæum. The urethra was next detached in front of the wound under the scrotum, so as to prevent an extension of the disease to the urethra next the bladder in the event of a return of the disease." The case was one of recurring epithelioma, and was published in the *Maryland Medical Journal* for July, 1877, page 117.

NEW YORK.

Correspondence.

THE PLASTER JACKET.

Dr. Bryan, of Lexington, defends his Claims to its Invention.

To the Editors of the Louisville Medical News:

A dreadful rumor having reached me that in a late number of the American Bi-Weekly magazine there was a very bitter criticism of me and my invention, I made search for the periodical among my brethren of the city. My diligence has at last been rewarded with a view of the mighty engine, and I have received its terrible load into my rash bosom. I beg of you the privilege of returning a cruel fire through your amiable columns.

It seems that the editor of the American Bi-Weekly has hit upon "a most remarkable and astounding article in one of the newspapers published at Lexington, Ky." He says "it is to the effect that Dr. Joseph Bryan, a young physician now practicing in Lexington, is the discoverer of the method of treating Pott's disease by the combined means of suspension and the use of the plaster-of-Paris jacket."

He does not tell us in what respect this article is either astounding or remarkable, but, with what most prudent people would

regard as extreme fool-hardiness, he draws his blade and forthwith plunges in *medias res*; that is, he proceeds to abuse me to just the extent he seems capable. Finally, he closes his article very self-complacently and evidently with the grim satisfaction of having lopped off one young doctor's head, and the determination to do likewise to the next young fellow who aspires to the honor of discovering or inventing any thing during the natural lifetime of the editor and proprietor of the American Medical Bi-Weekly.

If my memory serves me right, this is not the first time this editor has exhibited an unusual degree of recklessness; but, judging from the flaying he received as a penalty for it on a previous occasion—probably some four years [! ED. NEWS] ago—one would naturally have supposed that he had thoroughly learned the lesson of cautiousness; but

“Knowledge comes, but Wisdom lingers.”

In his first paragraph of abuse he insinuates, rather than openly avows, that I have “taken this method of advertising myself and splint, of setting forth incorrect and unjust claims, of appealing to popular sympathy and seeking popular support, of repudiating the spirit and text of the Code of Ethics,” etc., *ad nauseam*.

Of course this gentleman takes it for granted that I am the author or the article in question, or in some way responsible for or privy to its publication. But does he know this to be the fact? If he does know it, then there is some ground and some reason for the foregoing statements. If he does not know it, then his statements are unwarranted, without foundation in reason or in fact, and the whole matter simply goes to prove that my assailant is hasty and inaccurate, and therefore all his statements are to be taken *cum grano salis*. *But he does not know* any thing concerning the origin of the article that appeared in the Lexington press; nor does he know any thing of the motive that led to its publication. Therefore, let me ask, what right or reason has he to judge me or my motives? How does he

know I took this method of advertising myself? Without just grounds he has accused me of repudiating the spirit and text of the Code of Ethics. I now accuse him of repudiating the spirit of a code of a different nature, found spread over the pages of a volume that he evidently has but little knowledge of or use for.

Were it not rather ludicrous, it would be really affecting to behold what various inconsistencies and writhings and contortions this good man is compelled to undergo in order to say something flattering of his two great friends Dr. Sims and Dr. Sayre. How devotedly he stays at home and watches over their interests while they have gone off to Europe enjoying themselves. How courageously he defends them even from the attacks of editors of local newspapers. How *very* inconsistent he is. Does he not know that articles appeared in various Eastern and Northern newspapers, at New York, Saratoga, Chicago, and at other points, claiming the plaster-of-Paris jacket, and its method of application as an invention of Dr. Sayre, and advertising him as curing a disease that had hitherto been regarded as almost incurable? Did the editor of the Bi-Weekly pounce upon Dr. Sayre as he has done upon me? Did he accuse him of repudiating the text of the code, of advertising himself, of seeking popular sympathy and support, of transcending ethical propriety, etc., etc.? He did not, and it may be just as well for him to explain why he did not. All this unconsciously recalls a line that I doubt if the American Bi-Weekly editor has ever met with:

“He fawns on the proud feet that spurn him as they go.”

His next effort is to show that I am entitled to no claim of originality so far as suspension is concerned in the treatment of Pott's disease. This point he establishes to his own satisfaction by telling us that about the time I was born “Dr. J. K. Mitchell made direct traction upon the chin and occiput as a means of removing the weight of the head and upper part of the trunk

from the diseased vertebrae." He also tells us that "Dr. Benjamin Lee treated the spine thus as early as 1866," and "that he has a fixed suspension apparatus in his gymnasium for the treatment of spinal and nervous affections."

Well, all this has an air of school-boy logic about it, but there is little in it suggestive of the dignity and gravity of a full-grown man. In the first place, I have no doubt Dr. J. K. Mitchell did make direct traction upon the chin and occiput; in some cases, doubtless, he made too much, and in others probably too little; but in no case, I am bold to say, was he enabled to tell just when he had made sufficient to remove the superincumbent weight from the diseased bones, for this can only be done by suspending the patient. Dr. Sayre also tells us "that in turtle-shelling he made the proper amount of extension with the patient lying across his lap." But all this is wholly irrelevant, for suspension is not extension, neither is it traction upon the chin and occiput.

In the next place, he did not tell us what method Dr. Benjamin Lee used in 1866, but it may be safely asserted he did not suspend the patient and apply a plaster-of-Paris jacket to the spine. In the third place, Dr. Lee neither has now, and never did have a fixed suspension apparatus in his gymnasium for the treatment of Pott's disease of the spine. And so fades from the face of reason and logic all this gentleman's efforts to show that suspension had been used prior to the summer of 1874.

But now comes the unkindest cut of all; for although my critic "knows me neither personally or professionally," still he accuses me of being "absolutely ignorant of the commonest facts before the profession;" and says "I have no one to blame for this ignorance but myself." This from the discoverer of the similarity of scarlet fever and scarlatina. I bow my humbled head.

His next effort is to show that the plaster-of-Paris jacket does not differ in principle from any of the various spinal bandages, braces, and splints that have been used, or

the raw-hide jacket, or celluloid jacket of Darrach; and so far as his logic is concerned he might just as well have added the suspension apparatus in Lee's gymnasium, or Darrach's wheel-crutch, for some one principle is indeed involved in them all.

The plain truth of the matter is, the vast majority of the braces used in Pott's disease are intended simply to hold the spine erect, prevent motion, and allow ankylosis to take place, for they are all removed and reapplied at pleasure by the attendants of the patient. But in none of them are all the ideas combined, of straightening the spine, taking the superincumbent weight off the diseased bones, preventing motion at the point of disease, and holding the spine in an immovable position except in the plaster-of-Paris jacket. Probably the most convincing proof that could be adduced in support of this statement is the well-known fact that none of these braces do accomplish all these objects, and indeed none were ever intended to accomplish them all except the plaster jacket.

Heresofores I have made no public claim to the plaster-of-Paris jacket as an invention of my own simply because others, probably more capable, have done it for me, which fact the editor of the Bi-Weekly might have known but for his ignorance of the medical literature of New York city. And Dr. Sayre might still have talked about *his* plaster-of-Paris jacket until he had talked himself into a fit of the gout, and the Bi-Weekly and its editor might still have plodded their weary way on to oblivion, their inevitable destiny, unaccosted by me, but for this most unwarranted and unnecessary attack.

Now, however, I do not hesitate to state, and will maintain it when it becomes necessary, that in the summer of 1874, in Bellevue Hospital, I did, so far as I now know, suspend the first patient and apply the first plaster-of-Paris jacket for Pott's disease of the spine in this country.

As to the appearance of the article in the Lexington Press, I simply had nothing to do with it, I did not solicit its publication or

desire it. But if the editor of the Bi-Weekly wishes to know the motive that brought about its publication, I am assured he will be gratified by applying to the editor of the paper in which it appeared. But as to the appearance of the article in the Bi-Weekly perhaps the following lines may prove suggestive:

"O, faded leaf, is n't fame as brief?
What room is here for a hater!
Yet the yellow leaf hates the greener leaf,
For it hangs one moment later.

Greater than I, is n't that your cry?
And I shall live to see it;
Well, if it be so, so it is, you know;
And if it be so, so be it."

J. BRYAN.

Miscellany.

THE American Dermatological Association convened at Niagara Falls September 4th, remaining in session three days. This is the first annual meeting of the society, and its incorporators have reason to be gratified at its success. The number of dermatologists in America is small, no other specialty having so limited a following. Fifteen members attended this meeting, and seventeen papers were presented in addition to the president's address. Several of these were merely read by title and accepted. Several, after being read, were returned to their authors with thanks, they not being strictly dermatological. The following papers were read in full and discussed by the members: Molluscum Contagiosum, by Dr. George H. Fox, of New York; The Etiology of Cutaneous Diseases, by Dr. L. P. Yandell, jr., of Louisville; Eczema Marginatum, by Dr. Bulkley, of New York; The Pathology of Seborrhœa, by Dr. Van Harlingen, of Philadelphia; True Prurigo, by Dr. Robert Campbell, of New York; on Syphilis, by Dr. Hyde, of Chicago; on Syphilis, by Dr. Hardaway, of St. Louis; on Impetigo, by Dr. Heitzman, of New York; on Xeroderma, by Dr. R. W. Taylor, of New York; on Fragilitas Crinium, by Dr. Duhring, of Philadelphia;

on Syphilis, by Dr. R. W. Taylor, of New York; on Acute Diseases produced by Iodide of Potassium, by Dr. Brooks, of Chicago.

There were present Drs. White and Wiggleworth, of Boston; Drs. Duhring and Van Harlingen, of Philadelphia; Drs. Fox, Heitzman, Bulkley, Taylor, and Campbell, of New York; Drs. Hardaway, of St. Louis, Hyde, of Chicago, Yandell, of Louisville, Brodie, of Detroit, and Atkinson, of Baltimore. Dr. White was re-elected president, Drs. Bulkley and Heitzman, vice-presidents, Dr. Taylor, secretary, and Dr. Atkinson, treasurer. The Association meets next year at Saratoga.

The transactions will not be published by the society, but each member is at liberty to publish his paper in any medical journal of the country.

A "GENUINE MAD-STONE" has been exhibited at this office. It claims to be unrivaled in its particular line. The Harrodsburg stone or the lapideous wonder of the Northwest are fools beside this Koh-i-nûr of anti-hydrophobics. The paltry regiments which they have snatched from the locked jaws of death are nothing to the thousands it has limbered up. The use of the stone can be had on application by persons needing its services; and those who are in the habit of being bitten by mad-dogs had better apply early, for, as may be inferred, it is one of the rollingest stones on the continent. We may add that this G. M. S. is a very pretty specimen of recent coral.

THE last number of the Clinic contains Dr. Bartholow's opening paper on the question of typho-malarial fever, and Dr. Woodward—It is prefatory only to what is to follow—a slight skirmish with the gloves to try wind, etc. The real set-to can hardly be expected before the third or fourth round. The money is all up for this interesting mill, the police are balked, and the refreshing sport will surely proceed. Our flattering choice as referee in the match forbids any expression of opinion as to the outcome. We will endeavor to present faithful bulletins.

EMPTY capsules are undoubtedly one of the most useful pharmaceutical inventions of the day, and the Messrs. Planten will be remembered in the prayers of many an outraged palate for the relief their industry has wrought; but there are exceptions to all rules, and capsules have failed in one instance at least. A physician tells us that, having prescribed quinine for a patient (an intelligent gentleman from Boston) he directed it to be put in capsules. His patient afterward informed him that it was about the worst way of taking medicine he had ever tried. "How did you take it?" said the doctor; and the brilliant man replied, "*I peeled off the hulls, and put the stuff in water!*"! This is not the same party that had the leeches boiled.

NAPHEY'S THERAPEUTICS.—A new edition of this book is announced as soon to be ready. Dr. Brinton will edit the new edition, and of course will do it well. Large additions to the former text will be made, and the work will be issued in two volumes, sold separately: I. Medical Therapeutics; II. Surgical Therapeutics. We look forward to their advent with great interest.

A BRUTAL MURDER.—To illustrate the extreme care that is necessary in the practice of antiseptic surgery, Mr. Lister related to me the following case: He was opening under the spray a psoas abscess, the result of disease of the spine. His assistant, who was working the spray apparatus, becoming annoyed at a student behind him, and kicking at him, allowed the jet of spray for just an instant to be so directed as not to cover the opening he had just made. In great anger the doctor told his assistant that if that patient died, he might consider himself the cause of her death. She did die, and Mr. Lister believes that the misdirection of that jet of spray for the small fraction of a minute was the cause of her death.—*Correspondence of Chicago Medical Journal and Examiner.*

THE publishers of this journal will always be happy to supply missing copies of the LOUISVILLE MEDICAL NEWS to its subscribers when it is in their power. They only engage to do so, however, when application is made within a month after the journal should have arrived.

THE New Orleans Medical and Surgical Journal now appears as a monthly. The second number under the new arrangement comes with September. Dr. Bemiss has associated with him Drs. W. H. Watkins and G. K. Pratt as joint editors and proprietors. The New Orleans Medical Journal contains eighty octavo pages, and is issued at \$5 per annum. The reputation which the journal has already acquired is a guarantee for the future. We are pleased to think that we shall see it twice as often as we used to do.

DR. CONNEAU.—A Paris correspondent of the Daily News writes: "Dr. Conneau, one of the oldest friends of Napoleon III, and his private physician, died at Porta, in Corsica, on the 16th of August. He was born of French parents at Milan in 1803. While a medical student he became secretary to Louis Bonaparte, ex-king of Holland, and afterward he practiced medicine for a time in Rome. After the insurrection of 1831 he left Rome, and became household physician to Queen Hortense, Louis Napoleon's mother. He joined in the abortive Boulogne invasion, shared the prince's captivity in the fort of Ham, and contributed materially to his escape. He attached himself to the person of the prince in England, and returned with him to France after the Revolution of 1848. When the Empire was established Dr. Conneau was appointed principal physician to the household. He was in 1852 returned to the Corps Legislatif as a government candidate for the Somme, and continued a deputy until made a senator in 1867. His son and the prince imperial were for many years playmates. Queen Hortense left him a ring by her will, and expressed

the desire that her son might never separate from him. The emperor's friendship for him never flagged, and it is believed to be entirely owing to an oversight that no mention of him was made in his will. Dr. Conneau was liked by every body who knew him."—*British Medical Journal.*

FUNERAL REFORM.—The Press and Circular says: In our issue of July 11th we devoted some attention to the above subject, and we are pleased to find that our words have had some practical effect. Radical alterations and reforms require time, and though all the curtailment of expense and frippery may not follow, still there can be no doubt the common sense of the public will induce them to adopt the wise changes suggested. York has made the first step. In a circular or prospectus which has been forwarded to a number of influential inhabitants by the Rev. F. Lawrence, the rector of St. Mary's, Castlegate (hon. sec. *pro tem.*), the aims of the promoters are thus set forth: "The object shall be to endeavor, by unity, example, and persuasion, to abolish all unnecessary expenditure and show on the occasion of funerals and in the wearing of mourning, and by common consent to substitute a simple, quiet, and unostentatious ceremonial. The action of the association is to be in no way denominational, its members adopting the broad ground that funerals should be conducted and mourning worn without the dismal paraphernalia of hat-bands, scarfs, plumes, heavy crape trimmings, and the like, which are quite inconsistent with a hopeful belief in a future state, involve unprofitable expenditure, inflict severe hardships upon persons of limited means, and neither mitigate grief nor manifest respect for the dead."

SIMS has sailed at last! The Parthian shot is promised through the St. Louis Clinical Record.

LOUISIANA is endeavoring to form a state medical society.

Selections.

Therapeutics of Baldness.—As a prophylactic, brushing is of the first importance, as it promotes circulation and renovation, as well as removes scurf. Though advocating cleanliness to the utmost, to the question, "Am I to wash my head?" Mr. Wilson replies, emphatically, "No." Water is a less effective stimulant than brushing, even when sea-water is used. Cutting is less effective in promoting growth than is commonly believed, but is advantageously applied to the short, slender hairs commonly called "young hairs, and which are so often associated with baldness."

The number of applications warranted to cure baldness is legion, and their constant failure familiar to all. From the fat of the bear to the spirituous essence, most of them are stimulants, as is the petroleum lately vaunted. All occasionally seem to succeed; that is, the public observes that the hair grows after the use, and the public never experiences the fallacy of *post hoc ergo propter hoc* in matters therapeutic. Our readers will be glad to hear the experience of Professor Wilson on the use of some of these remedies, which we proceed to give, beginning with cantharides, acetic acid, and ammonia.

Croton Oil.—He found croton oil, although excellent as to its stimulating effects, peculiarly unmanageable as an application for the head. In one instance, in a young lady, it produced so much redness and swelling, symptoms which extended to the eyelids and face, that he was threatened with a legal prosecution for prescribing it. In a few days the swelling subsided; and as the hair grew again satisfactorily, he was let off without action or thanks. The croton oil having played a similar prank on a second occasion, he has discarded it.

Cantharides.—The milder and more manageable stimulation of cantharides has gained it a popular character, both as a stimulant and as an epispastic; but it also is not without its reverse. It is too apt to stretch its stimulative power to the extent of irritation, to give rise to inflammatory congestion and vesication, and sometimes to suppuration and ulceration. Every now and then it may come across a peculiarly sensitive skin, while at other times it may have been employed too energetically, both as to quantity and time. Mr. Wilson has seen several instances in which cantharidine has been absorbed into the system, and has given rise to ischuria. As a rule, therefore, he rarely uses cantharides, and then always in a guarded manner. Certainly it is not a remedy to be trusted to the acknowledged indiscretion of the public as a popular remedy.

Acetic acid, or rather strong pyrolygenous acid, he has discontinued for many years; but, judging from

the reports of those who have employed it, it is still a favorite, although its favor is somewhat alloyed by the convicting evidence of a strong and disagreeable odor.

Ammonia is Mr. Wilson's favorite. It may be limited easily to the bounds of stimulation; it is unlikely to create inflammation and its consequences; it is neither absorbable into the system, nor could it do harm if such were the case; and its odor, refreshing at the moment of its use, speedily evaporates. A formula for an ammonia lotion is to be found in Willan and Bateman's book. Ammonia is the active principle of a lotion for the hair of considerable reputation, called Locock's lotion; and it is also the essential ingredient of a lotion which is sold through the length and breadth of the kingdom under his name, and probably taken from some of his works.

Now, in a case of ordinary madesia or defluvium capillorum, the popular falling-out of the hair, he still prescribes a lotion composed of strong liquor ammoniae, almond oil, and chloroform, of each one part, diluted with five parts of spirits of wine or spirits of rosemary, and made pleasant as to fragrancy by the addition of a drachm of the essential oil of lemons. The instructions for the use of this lotion are that it should be dabbed upon the skin of the head after thorough friction with the hair-brush. No doubt there are cases in which this lotion must be used with caution. It may be diluted, if necessary; it may be applied sparingly or abundantly; and it may be used daily or otherwise.

There are cases in which a less stimulating and even a refrigerating lotion may be required, and where an objection may be raised to the quantity of oil contained in the former lotion; in which cases a lotion of borax and glycerine, two drachms of each to eight ounces of distilled water, is cooling and refreshing. This lotion allays dryness of the skin, removes scurf, and subdues irritability.

Treatment of complete Baldness.—In cases of complete baldness, the phalachrosis of the Greeks, and also in alopecia areata, a stronger stimulant application will be required. In such a case he recommends frictions with a liniment composed of equal parts of the liniments of camphor, ammonia, chloroform, and aconite, to be well rubbed into the bare places daily, or even twice a day, so as to produce a moderate amount of stimulation. In cases of ophiasis, due to neuralgia of the cutaneous nerves of the scalp, this liniment is very valuable. In other cases the liniment of iodine may be painted on the bare patches daily, or they may be stimulated by friction with the ointment of cantharides or any other powerful stimulant. Painting the discs of area with the epispastic fluid of the pharmacopoeia may also occasionally be resorted to, or the epispastic fluid may be diluted with spirits of camphor. The intention

of all these local remedies is to stimulate without setting up irritation, to increase the energy of circulation and innervation of the part, and in some instances to abstract the excess of fluids from the tissues of the skin by inducing exudation; but these results must be accomplished as far as possible without pain and without severity.

The constitutional treatment of alopecia should consist in the adjustment and regulation of the functions of digestion and assimilation, and, where no other special conditions are to be fulfilled, the adoption of a tonic regimen and the administration of tonic remedies. Of these last arsenic bears the palm, and may be advantageously prescribed in doses of two to four minims three times a day, directly after food, and in any convenient vehicle.

Alopecia syphilitica will yield very readily to the treatment applicable to the parent disease; namely, iodide of potassium, with the local inunction of the nitric-oxide-of-mercury ointment, diluted in the proportion of one part to three or four of benzoated lard or vaseline, or the use of a lotion of the perchloride of mercury.

Gray Hair.—With regard to grayness, canities, or poliothrix, it is to be observed that as it depends, like baldness, on defective powers of the skin, the indications for treatment are exactly the same—to strengthen the part and at the same time strengthen the patient. To fulfill these indications we may resort to the same prescriptions. When cure is not anticipated, and in other cases too, we may be asked to assist in concealing what is looked on as a deformity.

How to Stain the Hair.—Among temporary stainings for the hair he mentioned a weak solution of permanganate of potash, a lotion holding in suspension sulphur and acetate of lead, or the so-called *eau des Fées*, consisting of the hyposulphites of lead and soda. Among dyes, sulphides of various metals, especially silver, the pyrogallate of iron, and ferrocyanide of copper. The hair, as is well known, contains sulphur, and a solution of lead brought into contact with sulphur produces a sulphide of lead, which is black in color. Sulphur and acetate of lead in suspension and solution in water supply both the elements necessary for artificial coloration of the hair, and constitute the popular lotions sold so largely.

How to dye the Hair.—Actual dyeing of the hair is a more elaborate process. The hair must be washed with soap, in the first place, to get rid of grease, which would otherwise interfere with the absorption of the fluid by the hairy tissue; secondly, the hair being dried, the metallic solution is to be employed and left to soak into the hair; and thirdly, the mordant fluid is to be brushed upon the part with a view to bring it in contact with every individual hair. If this operation sufficed for a considerable period, all

would be well; but as we know that the hair grows quickly, the newly-grown part exhibits its original whiteness, and other dyeing soon becomes necessary. The tone of color produced by the first application may have been perfect, leaving nothing to be desired; but the white roots of the hair can not be reached without a fresh coloring being diffused over the whole, and then the evils become apparent: a succession of coats of color render the hair more intensely black than nature herself could have accomplished, and the harmony of the features of the individual is disturbed; the mellowing of the lineaments of the countenance produced by white hair is reversed by the depth of the blackness, and the features are rendered harsh and severe. The theory that an appearance of youth is maintained by the color of the hair is not consistent with fact, and there is always the danger that the hair may appear youthful while the features themselves are expressive of old age.

Dangers of Hair-dyes.—As to danger to the health and constitution from dyeing the hair, Prof. Wilson thinks that we can not reasonably allege the possibility of any serious evils; for lead, to which are imputed the most dangerous of the qualities of hair-dyes, enters into the composition of several of our cooling and astringent and sedative lotions, and even injections; and though undoubtedly some cases are on record of damage resulting from its internal and excessive use, Goulard's lotion is commonly received among us as one of the most harmless of our remedies. Perhaps a distinction may be drawn between its therapeutical and its cosmetical use, but it is difficult to distinguish the difference. It is fair, however, to state that one of our journals reports that "there died in Iowa Dr. Witherwax, from the effects of a hair-dye containing lead. He had employed the dye to his head and whiskers for four years, and during that period experienced many reminders in the shape of lead-colic. Two medical men detected lead in his liver and kidneys upon analysis." No further search would appear to have been prosecuted elsewhere; viz., in the direction of his drinking-water. Mr. Wilson remembers two instances in which complaint was made against a lead lotion used for the purpose of coloring the hair, although several have been mentioned to him from time to time; and both cases may possibly be considered as examples of idiosyncasy.—*Abstract of Erasmus Wilson's lecture, in The Doctor.*

Treatment of Ranula by Excision of Cyst.—In a contribution (*Gazette Hebdomadaire*, No. 16, 1877) giving short clinical reports of six cases of ranula observed by himself, Prof. Michel, of Nancy, discusses the nature and situation and the surgical treatment of this form of new growth. In each of these cases excision of the cyst was practiced with

complete success. From observations made during these six operations, and also from dissection of a ranula in a dead subject, the author has been convinced that, in the majority of instances of this affection, the cyst in its development has no connection with any of the salivary ducts. The view that ranula may be due to dilatation of the ducts of the sublingual or submaxillary glands is not altogether rejected; but it is held that, in the majority of cases, the cyst has some other seat of origin. In all the seven specimens examined by the author there was an absence of any connection between the cyst and the salivary canals, and in each case the tumor had evidently originated in the areolæ of the connective-tissue about the frenum of the tongue. The so-called capsule of Fleischmann, fluid distension of which is supposed by Tillaux and other French surgeons to constitute ranula, consists, according to Prof. Michel, in nothing more than an occasional and abnormal dilatation of one or more of the areolæ of the sublingual connective-tissue. On microscopical examination of the contents of the cyst in the above-mentioned seven cases, tessellated epithelium and crystals of cholesterin were found in some, and globular epithelium in others. In no specimen was the author able to obtain a reaction resembling that produced by saliva. Prof. Michel holds that extirpation by the knife ought to be regarded as the general method of treatment for ranula; and he argues that this proceeding, first recommended by Heister, is free from many of the objections that have been raised against it by Sedillot. Far from being an impracticable operation in ordinary cases of ranula, it may, even in cases of severity and long duration, be readily and safely performed. Excision, though more difficult than the usual methods of surgical treatment, such as injection of iodine, batrachosioplasty, and incision and cauterization combined, is attended with speedy as well as with most permanent results. No relapse had occurred in any of the six cases treated by the author, five of which have been under his observation from time to time during many years. Two methods of extirpation are mentioned; in one the ranula is first freely incised and the walls of the emptied cyst then dissected away, in the other the cyst is removed intact, together with its contents. The choice between one and the other of these methods should be guided by the thickness of the cyst-walls. When this wall is thin preliminary incision is to be preferred; when it is thick extirpation without incision should be practiced.—*British and Foreign Med.-Chir. Review.*

Matico in Post-partem Hemorrhage.—The use of matico in post-partem hemorrhage is doubtless of uncertain efficacy and its operations therein akin to empirical, but nevertheless in one case of obstinate

flooding I found it of some utility. I had no idea at the time that this astringent would have been beneficial, and I only used it, I may say, at a venture, as I had no ergot by me at the time. The preparation I used being the *tincture*, is not recognized by the British Pharmacopoeia, nor is there any mention of it either in Garrod's *Materia Medica* or Ringer's *Handbook of Therapeutics*, consequently it is not considered a therapeutic agent. I mention this fact in case some may be tempted to refer to those books, and not finding any notice of this preparation, conclude I am in error. It was the usual parallel case of post-partem hemorrhage which one now and then meets with in general practice; so to give a concise account of it would be puerile. Let it suffice when I tell my readers that I gave this tincture of matico instead of ergot, and the hemorrhage decreased from the time I administered it. I will not attempt to discuss the *modus operandi*, for it is not very plain. Naturally, this being an isolated case, one can not affirm with any degree of certainty that there is any real efficacy of matico in post-partem hemorrhage, or that its action therein is on a par with ergot, because one single case is not sufficient for one to arrive at such a conclusion; besides it would be an absurdity; however, it is deserving of some consideration. It seems possible, nevertheless, that if matico is useful in staying bleeding on free surfaces, it might be used with advantage in uterine hemorrhage; most decidedly it would not cause those painful contractions of the uterus, as ergot usually does. One very useful hint may be learned from this case, however, and that is, an injection of a liquid preparation of matico, such as the infusion, would be quite as advantageous and not so dangerous as perchloride of iron injection, which has been known to cause a fatal termination. Therefore, as nothing of a pernicious nature could possibly ensue from an injection of the infusion of matico, it is much preferable to an injection of the perchloride of iron.—*E. Marlett Boddy, in Med. Press and Circular.*

Chloral in Infantile Convulsions.—During the past year I have been called upon to treat about forty cases of infantile convulsions, many of them presenting symptoms of a most alarming nature; and in four or five instances the appearances being almost hopeless I at first tried free purgation, bathing the feet in mustard and hot water, and the administration of five-grain doses of bromide of potassium to children over nine months of age. Not being satisfied with the rapidity of results obtained, I began to combine chloral hydrate in two-grain doses with the bromide mixture, and found the combination to act with the happiest results. I am glad to find myself confirmed in the beneficial results to be obtained by this treatment

by the following extract from the Canada Medical Record: "Lowenstamm (Medicinisch - Chirurgisches Centralblatt) speaks of numerous instances in which he has tested the efficacy of this drug in convulsions, and he gives one case in detail. The patient was the third child of a highly nervous woman, who had lost her first and second children from this affection at about the same age as that at which this one was attacked. At the thirteenth day twitching of the eyelids and of the angles of the mouth were first observed; these rapidly developed into more general convulsions, which were repeated, later, every ten minutes. The infant was first seen on the sixteenth day of life. He showed then strong twitchings of the face, trismus, clonic spasms of the limbs, spastic contractions of the thumbs, and contracted pupils; the fit terminated, at the end of five minutes, in profuse perspiration. Two grains of chloral hydrate were given every hour. The convulsions diminished in frequency and intensity, and on the following day he was free from them. As the case was considered to depend upon dyspepsia, an antacid in the form of magnesia usta was then given, and no recurrence took place."—*John W. Martin, M. D., in London Med. Record.*

Treatment of Eclampsia.—Dr. Charles (Memoirs of the Belgian Academy of Medicine, 1876) sums up as follows the treatment of eclampsia, in his memoir on the convulsions of parturient women, which was crowned by the Belgian Academy of Medicine. 1. Mechanical eclampsia from the sixth to the ninth month: (a) bleeding, if the case be urgent, or if there be true or apparent plethora; (b) drastics, in all cases, which may be more or less replaced by diaphoresis; (c) chloroform when the fits are about to commence and during the clonic convulsions; (d) chloral in the intervals of the attacks as an injection to beneficially fill the place of narcotics; any antispasmodic, such as bromide of potassium, may be added to it; (e) to finish the delivery if possible; bring on labor, if the fits do not show signs of disappearing; to bring on forced delivery in very serious cases. 2. Reflex eclampsia before six months' gestation and after delivery: (a) bleeding is but very rarely indicated; (b) purgatives are always somewhat useful; (c) chloroform, chloral, etc., should be continued as in mechanical eclampsia; and antispasmodics should not be neglected. 3. Toxic eclampsia. Fulfill the symptomatic indications; general or local bleedings to combat congestion of the brain and spinal cord when it is very marked; cold applications to the head, purgatives, diaphoretics, baths, revulsives, narcotics, anæsthetics, etc.—*London Med. Record.*

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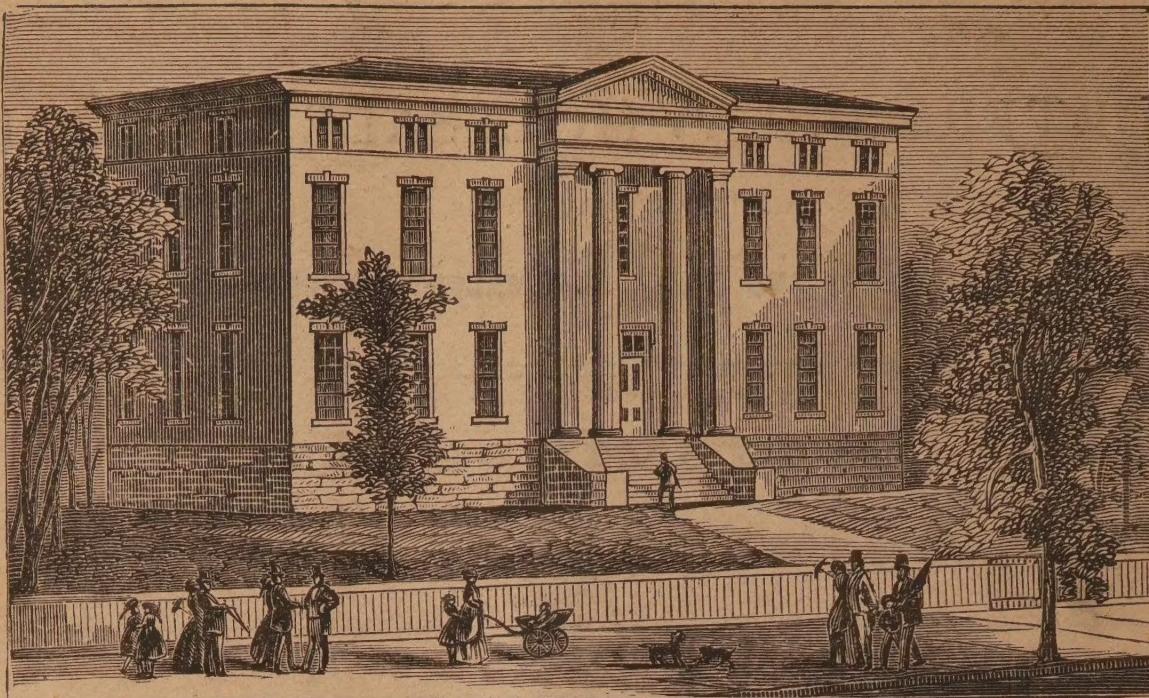
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